The Rise of Cesarean Sections

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Introduction

Over the past several years, there has been much discussion and debate concerning the steady rise in the rate of cesarean section births. The number of cesarean sections being performed has increased every year, with data from the National Vital Statistics System showing that in 2006, 31% of births were performed by c-section (CDC, 2006). Much of the discussion centers on the safety of cesarean sections versus vaginal deliveries for both maternal and neonatal outcomes. However, another topic being hotly debated is the underlying cause of the increasing rate. Many point to "cesarean delivery on maternal request" as the prime reason the rate has skyrocketed. This is a topic of great importance. It is quite surprising that most medical personnel accept that up to 31% of babies are being delivered via a major abdominal surgery simply due to mothers requesting. This paper will review the ethical implications of elective cesarean sections, specifically the issues of patient autonomy and beneficence/nonmaleficence, and how they relate to cesarean delivery on maternal request (CDMR).

Review of Literature

When considering the ethical aspects of elective cesarean deliveries, it is necessary to first determine if the procedure is any safer or riskier than vaginal deliveries. In a large, multicenter study in Latin America, researchers concluded that cesarean deliveries do reduce overall risk in breech presentations. However, in cephalic presentations, c-section deliveries significantly increase risk of both maternal and neonatal morbidity and mortality. The researchers' overall conclusion from their study was that the "increase in rates of cesarean delivery at an institutional level is not associated with any clear overall benefit for the baby or mother but is linked with increased morbidity for both" (Villar et al., 2007, p. 1025).

Similar results were seen in the study conducted by Kolas, Saugstad, Daltveit, Nilsen, and Oian (2006). After comparing planned cesarean births with planned vaginal births, they found that infants born via c-section had a significantly higher risk of being transferred to the neonatal intensive care unit and had significantly more pulmonary disorders. They went on to further analyze the data to determine if high-risk pregnancies may adversely skew the results of the planned c-section group by excluding data from c-section deliveries which were planned due to fetal indicators. This re-analysis showed no significant difference from the original results.

It has been suggested by some that the reason cesarean sections "appear" less safe than vaginal deliveries in some studies is due to the inclusion of emergency c-sections which are known to have more complications than planned c-sections. To address this, Quiroz, Chang, Blomquist, Okoh, and Handa (2009) conducted a study to compare vaginal delivery outcomes with both c-section deliveries performed before the onset of labor (UCD – unlabored cesarean delivery) and those performed after the onset of labor (LCD – labored cesarean delivery). They concluded that both the LCD (labored) and vaginal delivery groups had a higher risk of bleeding than the UCD (unlabored) group but that the UCD (unlabored) group had significantly more neonatal complications than either of the other two groups. When adjusting for fetal indications for cesarean delivery in the UCD (unlabored) group which could be risk factors for neonatal complications, it was found that there was no significant difference in neonatal complications between the UCD and LCD groups. However, the odds of experiencing complications were 37% lower for neonates born vaginally (Quiroz, et al., 2009).

All three of the studies discussed acknowledge that much more research needs to be done to better understand the risks and benefits of cesarean deliveries. None of them, however, concluded that cesarean deliveries are safe enough to be routinely offered. What, then, is leading

to the record high rate? One possibility is simply that more women need cesarean sections due to complications encountered with their pregnancy. This could be due to more women waiting until they are older to have children or because of the increased incidence of multiple births. Declercq et al. (as cited in "Why does the cesarean section rate keep going up", 2007), however, found that the rate of c-sections has gone up in all groups of women "regardless of age, the number of babies they're having, the extent of health problems, their race/ethnicity, or other breakdowns (para. 6)". It seems, from this information, that maternal health considerations are not the cause of the increase.

Many practitioners and lay persons interested in the topic have come to accept that the true reason for the increase in c-section rates is due to an increase in elective cesarean sections, specifically cesarean delivery on maternal request (CDMR). The National Institutes of Health State-of-the-Science Conference Statement (2006, p. 1386) defines cesarean delivery on maternal request as "a cesarean delivery for a singleton pregnancy on maternal request at term in the absence of any medical or obstetric indications". In other words, CDMR is elective surgery without medical necessity.

The American College of Obstetricians and Gynecologists published a committee opinion, "Surgery and Patient Choice" (2003), which addressed ethical considerations of such elective surgeries as CDMR. They sought to guide OB/GYN physicians in making decisions regarding patient requested surgeries when medical indication is lacking. The committee appropriately asked the question "should health care options be regarded in the same way as choice of cereal in the supermarket" (ACOG, 2003, p. 188). One of the central issues involved is patient autonomy. Patients should be the ones to determine what is done to their own bodies, including having the choice to have or not have a surgical procedure such as a cesarean section.

How is autonomy handled, however, when it conflicts with other ethical elements such as beneficence and nonmaleficence? The ACOG committee recognized that, in decision making, physicians must "consider the maintenance of the dignity and honor of the discipline of obstetrics and gynecology and its standards of care", and that "even though the decision of the patient should be respected, this might not include supporting the decision, particularly when doing so is in direct conflict with other guiding ethical principles" (ACOG, 2003, p. 189).

The other guiding principles involved are beneficence, promoting the health and well-being of the patient, and nonmaleficence, doing no harm to the patient. Cesarean births have not been proven to be of any benefit to mother or child in uncomplicated pregnancies. Therefore, a physician may actually be violating the principles of beneficence and nonmaleficence when agreeing to an elective c-section request by putting the mother and child at unnecessary risk of harm. The ACOG committee determined that when patient autonomy and beneficence/nonmaleficence are in conflict, "the patient has the right to refuse unwanted treatment…she does not, however, have a parallel right to demand treatment that the physician believes is unwise or overly risky" (2003, p. 189).

Conclusion

It is clear from the above information that there are many different variables to consider when deciding on a method of delivery, both for mothers and for physicians. Since cesarean delivery has not been shown to be safer than vaginal delivery in uncomplicated pregnancies, this option should not be routinely offered to mothers as a choice for them to make. However, when confronted with a mother requesting a cesarean section without medical indication, physicians have the responsibility to weigh their patient's autonomy against their obligation to uphold the principles of beneficence and nonmaleficence. Nursing staff, as well, have the same obligation

to uphold these ethical guidelines. A primary responsibility of nursing is to act as a patient advocate. As Miesnik and Reale (2007) point out, nurses are ideally situated to assess a woman's knowledge about cesarean delivery and educate her on the risks and benefits. Perinatal nurses, nurse practitioners, and nurse midwives can advocate for their patients and uphold their autonomy by exploring reasons for requesting cesarean deliveries (Miesnik & Reale, 2007). Beneficence and nonmaleficence can be upheld by avoiding unnecessary c-sections which are requested due to fear of birth and labor pain. Nurses can advocate for continuous nursing support during labor and educate women on the availability of medication to control pain during labor (Miesnik & Reale, 2007). Both physicians and nurses are equipped with ways to work towards decreasing the national rate of cesarean deliveries, as well as an ethical obligation to do so.

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